

Welcome to Planned Parenthood of Idaho!!

We appreciate you choosing Planned Parenthood of Idaho for your healthcare needs. To ensure that we have your current information in our system, we ask that you carefully fill out this form yearly (or sooner if anything has changed) and provide us with all the necessary information.

Date: _____ Patient Label here
Social Security Number: _____

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Phone Contact: _____
Home Work Other

Date of Birth : ____/____/____ Age: _____ Sex: M F
month day year

Race (Optional): White Non-Hispanic (1)/ Multiracial Hispanic (10)/ Multiracial Non-Hispanic (9)/ Black Non-Hispanic (3)/ American Indian(5)/ Alaskan Native (6)/ Asian Pacific Islander Non Hispanic(7)/ Unknown (13)
Other: _____

If under the age of 18, are your parents aware you are here today? Yes No

What birth control method are you currently using?: Condoms-Male or Female(NPB)/ Birth Control Pills (OC)/ Patch(PT) Nuva Ring (RI)/ Diaphragm-Cervical Cap (PBM)/ Depo Provera (DP)/ IUD (IUD)/ Sterilization (ST)/ Natural Family Planning (NF)/ Other (OT)/ No Method (NO)

How may we contact you? Mail _____ Phone _____ Both _____

**Please Note: Planned Parenthood of Idaho will send statements to those patients over 18 years old with outstanding balances. Planned Parenthood of Idaho may also need to send test results to the address provided if patient is unavailable by phone. For most of the tests PPI provides, "No news is good news." Confidentiality may be broken if you cannot be contacted via the information you have provided, should a life threatening condition be suspected or detected.*

What services do you need today? Please describe: _____

Emergency Contact: _____ Phone: _____
First Last Relationship

Would you like to give permission to PPI to dispense your medication to a friend/family member? Yes No

Would you like to give permission to PPI to discuss or release your medical information to anyone besides you? Yes No

Do you have Medicaid ___yes ___no Do you have health insurance ___yes ___no

**If you have Medicaid or Health Insurance please provide staff with your current card.*

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE!! _____
Initials

If you need financial assistance, please provide the following information. (you must provide the staff with proof of income such as a bank statement or pay stub.)

Monthly Income _____ Number supported by income _____ Staff Initials _____

I assign my insurance benefits to Planned Parenthood of Idaho (PPI). I agree to pay for all charges not paid by the insurance company. I authorize PPI to release all or part of my medical records to any person or organization liable for payment. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I certify that to the best of my knowledge, the above information is true. I request that a person authorized by PPI provide appropriate evaluation, testing and treatment.

Patient Signature _____ Date _____